Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name:
SOUTHERN VANGUARD

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number:
M4-12-3090-01

MDFR Received Date
June 11, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "This med is for pain & inflammation to function. With this meds I can function daily. Pain & nerve damage if I stop the pain gets worse. With these the pain subsides. I have to take this for nausea with pain meds."

Amount in Dispute: $94.46

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This medical fee dispute should be disputed. The requestor is an injured worker who is seeking reimbursement for prescription medication the employee allegedly paid out-of-pocket for between March 29, 2012 and June 7, 2012. While an injured worker is not required to seek reconsideration of a denial of reimbursement prior to requesting medical dispute resolution…, the injured worker must present the request for reimbursement to the carrier at least once prior to seeking medical dispute resolution… Because the claimant failed to do so in the present case, dismissal of this dispute is appropriate… The carrier submits this medical dispute should be dismissed for the reasons outlined above. In addition, with regard to the merits of the dispute, the carrier would note that the medication use is not medically necessary as treatment for the claimant's compensable injury. The claimant has failed to request an Independent Review Organization to address the medical necessity issues."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 29, 2012 through June 7, 2012	Out-of-Pocket expenses for prescription medications.	$94.46	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for injured employees to pursue a medical fee dispute.

Issues

1. Did the requestor submit the out-of-pocket expenses for the services in dispute in accordance with 28 Texas Administrative Code §133.307?
2. Did the respondent raise the medical necessity of the medications in their response?

Findings

1. Pursuant to Texas Administrative Code §133.307(c)(4)(I) a copy of the insurance carrier's or health care provider's denial of reimbursement or refund relevant to the dispute, or, if no denial was received, convincing evidence of the injured employee's attempt to obtain reimbursement or refund from the insurance carrier or health care provider. Review of the submitted documentation does not contain a denial of reimbursement from the insurance carrier or convincing evidence of the injured worker's attempt to obtain reimbursement.

2. According to the respondents position summary, "the medication use is not medically necessary as treatment for the claimant's compensable injury." 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. 28 Texas Administrative Code §137.100 Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.

Conclusion

For the reasons stated above, the division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October 11, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.